



**Aetna Medicare Premier Plus Plan (PPO) offered by AETNA LIFE INSURANCE COMPANY**

# Annual Notice of Changes for 2024

You are currently enrolled as a member of Aetna Medicare Premier Plus Plan (PPO). Next year, there will be changes to the plan's costs and benefits. **Please see page 4 for a Summary of Important Costs, including Premium.**

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at [AetnaMedicare.com](https://www.aetna.com/AetnaMedicare.com). You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

---

## What to do now

### 1. **ASK:** Which changes apply to you

- Check the changes to our benefits and costs to see if they affect you.
  - Review the changes to Medical care costs (doctor, hospital).
  - Review the changes to our drug coverage, including authorization requirements and costs.
  - Think about how much you will spend on premiums, deductibles, and cost sharing.
- Check the changes in the 2024 "Drug List" to make sure the drugs you currently take are still covered.
- Check to see if your primary care doctors, specialists, hospitals and other providers, including pharmacies will be in our network next year.
- Think about whether you are happy with our plan.

### 2. **COMPARE:** Learn about other plan choices

- Check coverage and costs of plans in your area. Use the Medicare Plan Finder at [www.medicare.gov/plan-compare](https://www.medicare.gov/plan-compare) website or review the list in the back of your *Medicare & You 2024* handbook.
- Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

Y0001\_H5521\_170\_PQ20\_ANOC24\_M

OMB Approval 0938-1051 (Expires: February 29, 2024)

**3. CHOOSE:** Decide whether you want to change your plan

- If you don't join another plan by December 7, 2023, you will stay in Aetna Medicare Premier Plus Plan (PPO).
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2024**. This will end your enrollment with Aetna Medicare Premier Plus Plan (PPO).
- If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

**Additional Resources**

- This document is available for free in Spanish. Este documento está disponible sin cargo en español.
- Please contact our Member Services number at 1-833-570-6670 or the number on your member ID card for additional information. (TTY users should call 711.) Hours are 8 AM to 8 PM, 7 days a week. This call is free.
- This document is available in other formats such as braille, large print or other alternate formats upon request.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at [www.irs.gov/Affordable-Care-Act/Individuals-and-Families](http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families) for more information.

**About Aetna Medicare Premier Plus Plan (PPO)**

- Aetna Medicare is a HMO, PPO plan with a Medicare contract. Our DSNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal.
- When this document says "we," "us," or "our," it means AETNA LIFE INSURANCE COMPANY. When it says "plan" or "our plan," it means Aetna Medicare Premier Plus Plan (PPO).

## **Annual Notice of Changes for 2024**

### **Table of Contents**

<b>Summary of Important Costs for 2024</b>		<b>4</b>
<b>SECTION 1</b>	<b>Changes to Benefits and Costs for Next Year</b>	<b>7</b>
Section 1.1	Changes to the Monthly Premium	7
Section 1.2	Changes to Your Maximum Out-of-Pocket Amounts	7
Section 1.3	Changes to the Provider and Pharmacy Networks	7
Section 1.4	Changes to Benefits and Costs for Medical Services	9
Section 1.5	Changes to Part D Prescription Drug Coverage	17
<b>SECTION 2</b>	<b>Deciding Which Plan to Choose</b>	<b>20</b>
Section 2.1	If you want to stay in Aetna Medicare Premier Plus Plan (PPO)	20
Section 2.2	If you want to change plans	20
<b>SECTION 3</b>	<b>Deadline for Changing Plans</b>	<b>21</b>
<b>SECTION 4</b>	<b>Programs That Offer Free Counseling about Medicare</b>	<b>21</b>
<b>SECTION 5</b>	<b>Programs That Help Pay for Prescription Drugs</b>	<b>22</b>
<b>SECTION 6</b>	<b>Questions?</b>	<b>22</b>
Section 6.1	Getting Help from Aetna Medicare Premier Plus Plan (PPO)	22
Section 6.2	Getting Help from Medicare	23

## Summary of Important Costs for 2024

The table below compares the 2023 costs and 2024 costs for Aetna Medicare Premier Plus Plan (PPO) in several important areas.

**Please note this is only a summary of costs.**

Cost	2023 (this year)	2024 (next year)
<b>Monthly plan premium*</b> * Your premium may be higher than this amount. (See Section 1.1 for details.)	\$0	\$0
<b>Maximum out-of-pocket amounts</b> This is the <u>most</u> you will pay out-of-pocket for your covered services. (See Section 1.2 for details.)	From network providers: \$4,500  From network and out-of-network providers combined: \$8,950	From network providers: \$4,500  From network and out-of-network providers combined: \$5,500
<b>Doctor office visits</b>	<u>In-Network:</u> Primary care visits: \$0 copay per visit  Specialist visits: \$25 copay per visit  <u>Out-of-Network:</u> Primary care visits: \$55 copay per visit  Specialist visits: \$60 copay per visit	<u>In-Network:</u> Primary care visits: \$0 copay per visit  Specialist visits: \$20 copay per visit  <u>Out-of-Network:</u> Primary care visits: \$10 copay per visit  Specialist visits: \$30 copay per visit
<b>Inpatient hospital stays</b>	<u>In-Network:</u> \$295 per day, days 1-6; \$0 per day, days 7-90; \$0 copay for additional days for each medically necessary covered inpatient stay.  <u>Out-of-Network:</u> 50% per stay	<u>In-Network:</u> \$295 per day, days 1-6; \$0 per day, days 7-90; \$0 copay for additional days for each medically necessary covered inpatient stay.  <u>Out-of-Network:</u> \$395 per day, days 1-6; \$0 per day, days 7-90

Cost	2023 (this year)	2024 (next year)
<p><b>Part D prescription drug coverage</b> (See Section 1.5 for details.)</p>	<p>Deductible: \$0</p> <p>Copayment/Coinsurance during the Initial Coverage Stage: <i>Preferred cost-sharing</i> (One-month supply):</p> <ul style="list-style-type: none"> <li>• Drug Tier 1: \$0</li> <li>• Drug Tier 2: \$5</li> <li>• Drug Tier 3: \$47 You pay \$35 per month supply of each covered insulin product on this tier.</li> <li>• Drug Tier 4: \$100</li> <li>• Drug Tier 5: 33% You pay \$35 per month supply of each covered insulin product on this tier.</li> </ul> <p><i>Standard cost-sharing</i> (One-month supply):</p> <ul style="list-style-type: none"> <li>• Drug Tier 1: \$3</li> <li>• Drug Tier 2: \$7</li> <li>• Drug Tier 3: \$47 You pay \$35 per month supply of each covered insulin product on this tier.</li> <li>• Drug Tier 4: \$100</li> <li>• Drug Tier 5: 33% You pay \$35 per month supply of each covered insulin product on this tier.</li> </ul> <p>Catastrophic Coverage:</p> <ul style="list-style-type: none"> <li>• During this payment stage, the plan pays most of the cost for your covered drugs.</li> <li>• For each prescription, you pay whichever of these is larger: a payment equal to 5% of the cost of the drug (this is called “coinsurance”), or a copayment (\$4.15</li> </ul>	<p>Deductible: \$0</p> <p>Copayment/Coinsurance during the Initial Coverage Stage: <i>Preferred cost-sharing</i> (One-month supply):</p> <ul style="list-style-type: none"> <li>• Drug Tier 1: \$0</li> <li>• Drug Tier 2: \$5</li> <li>• Drug Tier 3: \$47 You pay \$35 per month supply of each covered insulin product on this tier.</li> <li>• Drug Tier 4: \$100</li> <li>• Drug Tier 5: 33% You pay \$35 per month supply of each covered insulin product on this tier.</li> </ul> <p><i>Standard cost-sharing</i> (One-month supply):</p> <ul style="list-style-type: none"> <li>• Drug Tier 1: \$5</li> <li>• Drug Tier 2: \$10</li> <li>• Drug Tier 3: \$47 You pay \$35 per month supply of each covered insulin product on this tier.</li> <li>• Drug Tier 4: \$100</li> <li>• Drug Tier 5: 33% You pay \$35 per month supply of each covered insulin product on this tier.</li> </ul> <p>Catastrophic Coverage:</p> <ul style="list-style-type: none"> <li>• During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.</li> </ul>

*This service is continued on the next page*

Cost	2023 (this year)	2024 (next year)
<b>Part D prescription drug coverage</b> (continued)		
	for a generic drug or a drug that is treated like a generic, and \$10.35 for all other drugs).	

**SECTION 1 Changes to Benefits and Costs for Next Year**

**Section 1.1 Changes to the Monthly Premium**

<b>Cost</b>	<b>2023 (this year)</b>	<b>2024 (next year)</b>
<b>Monthly premium</b> (You must also continue to pay your Medicare Part B premium.)	\$0	\$0

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.

**Section 1.2 Changes to Your Maximum Out-of-Pocket Amounts**

Medicare requires all health plans to limit how much you pay out-of-pocket for the year. These limits are called the maximum out-of-pocket amounts. Once you reach this amount, you generally pay nothing for covered services for the rest of the year.

<b>Cost</b>	<b>2023 (this year)</b>	<b>2024 (next year)</b>
<b>In-network maximum out-of-pocket amount</b>  Your costs for covered medical services (such as copays) from network providers count toward your in-network maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	\$4,500	\$4,500  Once you have paid \$4,500 out-of-pocket for covered services, you will pay nothing for your covered services from network providers for the rest of the calendar year.
<b>Combined maximum out-of-pocket amount</b>  Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your costs for outpatient prescription drugs do not count toward your maximum out-of-pocket amount for medical services.	\$8,950	\$5,500  Once you have paid \$5,500 out-of-pocket for covered services, you will pay nothing for your covered services from network or out-of-network providers for the rest of the calendar year.

**Section 1.3 Changes to the Provider and Pharmacy Networks**

Updated directories are located on our website at [AetnaMedicare.com/findprovider](https://www.aetna.com/medicare/find-provider) or [AetnaMedicare.com/findpharmacy](https://www.aetna.com/medicare/find-pharmacy). You may also call Member Services for updated provider and/or pharmacy information or to ask us to mail you a directory, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2024 Provider & Pharmacy Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

There are changes to our network of pharmacies for next year. **Please review the 2024 Provider & Pharmacy Directory to see which pharmacies are in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Member Services so we may assist.



## Section 1.4 Changes to Benefits and Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

<b>Cost</b>	<b>2023 (this year)</b>	<b>2024 (next year)</b>
<b>Acupuncture for chronic low back pain</b>	In-Network: You pay a \$25 copay for each Medicare-covered service.	In-Network: You pay a \$20 copay for each Medicare-covered service.
<b>Acupuncture for chronic low back pain</b>	Out-of-Network: You pay a \$60 copay for each Medicare-covered service.	Out-of-Network: You pay a \$30 copay for each Medicare-covered service.
<b>Ambulance services (air)</b>	In-Network: You pay a \$260 copay for each Medicare-covered service.	In-Network: You pay a \$275 copay for each Medicare-covered service.
<b>Ambulance services (air)</b>	Out-of-Network: You pay a \$260 copay for each Medicare-covered service.	Out-of-Network: You pay a \$275 copay for each Medicare-covered service.
<b>Ambulance services (ground)</b>	In-Network: You pay a \$260 copay for each Medicare-covered service.	In-Network: You pay a \$275 copay for each Medicare-covered service.
<b>Ambulance services (ground)</b>	Out-of-Network: You pay a \$260 copay for each Medicare-covered service.	Out-of-Network: You pay a \$275 copay for each Medicare-covered service.
<b>Cardiac rehabilitation services</b>	In-Network: You pay a \$40 copay for each Medicare-covered service.	In-Network: You pay a \$35 copay for each Medicare-covered service.
<b>Cardiac rehabilitation services</b>	Out-of-Network: You pay 50% of the total cost for each Medicare-covered service.	Out-of-Network: You pay 20% of the total cost for each Medicare-covered service.
<b>Chiropractic services</b>	Out-of-Network: You pay 50% of the total cost for each Medicare-covered service.	Out-of-Network: You pay 20% of the total cost for each Medicare-covered service.
<b>Continuous glucose monitors</b>	Continuous glucose monitors must be obtained at an in-network DME provider.	You can get a Dexcom or FreeStyle Libre brand continuous glucose monitor and supplies at a participating pharmacy location or participating DME provider. If you choose any other brand, you can only use a participating DME provider.  You will need a prescription to get your monitor and supplies.

Cost	2023 (this year)	2024 (next year)
<b>Dental services</b>	In-Network: You pay a \$25 copay for each Medicare-covered service.	In-Network: You pay a \$20 copay for each Medicare-covered service.
<b>Dental services</b>	Out-of-Network: You pay 50% of the total cost for each Medicare-covered comprehensive dental service.	Out-of-Network: You pay 20% of the total cost for each Medicare-covered comprehensive dental service.
<b>Dental services (additional)</b>	<p>Additional dental services maximum benefit: Plan pays up to \$1,500 every year for non-Medicare covered preventive dental services and non-Medicare covered comprehensive dental services combined.</p> <p>With this Total Choice Dental benefit, you can choose to receive these dental services from an Aetna Dental PPO Network provider or a provider not in our network.</p> <p>Network providers agree to bill us directly so you won't have to pay upfront. They can also help you save money.</p> <p>If you choose a provider that is not in the Aetna Dental PPO Network you may have higher costs. If a provider not in our network is not willing to bill us directly, you may have to pay upfront and submit a request for reimbursement.</p> <p>See the <i>Evidence of Coverage</i> for more information.</p>	<p>Additional dental services maximum benefit: Plan pays up to \$2,900 every year for non-Medicare covered preventive dental services and non-Medicare covered comprehensive dental services combined.</p> <p>With this Total Choice Dental benefit, you can choose to receive these dental services from an Aetna Dental PPO Network provider or a provider not in our network.</p> <p>Network providers agree to bill us directly so you won't have to pay upfront. They can also help you save money.</p> <p>If you choose a provider that is not in the Aetna Dental PPO Network you may have higher costs. If a provider not in our network is not willing to bill us directly, you may have to pay upfront and submit a request for reimbursement.</p> <p>See the <i>Evidence of Coverage</i> for more information.</p>
<b>Dental services (additional)</b>	<p>Out-of-Network: Preventive dental services: • \$0 copay</p> <p>Comprehensive dental services: • \$0 copay</p>	<p>Out-of-Network: Preventive dental services: • 20% coinsurance</p> <p>Comprehensive dental services: • 20% coinsurance</p>
<b>Diabetes self-management training services</b>	Out-of-Network: You pay 50% of the total cost for each Medicare-covered service.	Out-of-Network: You pay 20% of the total cost for each Medicare-covered service.
<b>Diagnostic procedures and tests</b>	Out-of-Network: You pay 50% of the total cost for each Medicare-covered service.	Out-of-Network: You pay 20% of the total cost for each Medicare-covered service.

Cost	2023 (this year)	2024 (next year)
<b>Diagnostic radiology services</b>	Out-of-Network: You pay 50% of the total cost for each Medicare-covered service.	Out-of-Network: You pay 20% of the total cost for each Medicare-covered service.
<b>Durable medical equipment (DME) and related supplies</b>	Out-of-Network: You pay 45% of the total cost for each Medicare-covered item.	Out-of-Network: You pay 20% of the total cost for each Medicare-covered item.
<b>Emergency care</b>	You pay a \$90 copay for each Medicare-covered service.	You pay a \$100 copay for each Medicare-covered service.
<b>Emergency care (worldwide)</b>	You pay a \$90 copay for each non-Medicare covered service.  There is a \$250,000 combined maximum benefit for worldwide emergency and urgent care annually.	You pay a \$100 copay for each non-Medicare covered service.  There is a \$250,000 combined maximum benefit for worldwide emergency and urgent care annually.
<b>Emergency transportation (worldwide)</b>	You pay a \$260 copay for each non-Medicare covered service.  There is a \$250,000 combined maximum benefit for worldwide emergency and urgent care annually.	You pay a \$275 copay for each non-Medicare covered service.  There is a \$250,000 combined maximum benefit for worldwide emergency and urgent care annually.
<b>Eye exams</b>	In-Network: You pay a \$0-\$25 copay for each Medicare-covered service. The minimum cost share is for diabetic eye exams. The maximum cost share is for all other Medicare-covered eye exams.	In-Network: You pay a \$0-\$20 copay for each Medicare-covered service. The minimum cost share is for diabetic eye exams. The maximum cost share is for all other Medicare-covered eye exams.
<b>Eye exams</b>	Out-of-Network: You pay a \$60 copay for each Medicare-covered service.	Out-of-Network: You pay a \$30 copay for each Medicare-covered service.
<b>Eye exams (non-Medicare covered)</b>	Out-of-Network: You pay a \$60 copay for each non-Medicare covered service (one exam every year). The number of visits includes services from both network and out-of-network providers.	Out-of-Network: You pay a \$30 copay for each non-Medicare covered service (one exam every year). The number of visits includes services from both network and out-of-network providers.
<b>Eyewear</b>	Out-of-Network: You pay 50% of the total cost for each Medicare-covered item.	Out-of-Network: You pay 20% of the total cost for each Medicare-covered item.

Cost	2023 (this year)	2024 (next year)
<b>Eyewear — prescription (non-Medicare covered)</b>	<p>Non-Medicare covered eyewear allowance: Plan reimburses up to \$135 every year for non-Medicare covered prescription eyewear.</p> <p>You do not have to use an in-network provider for your non-Medicare covered eyewear services. See the <i>Evidence of Coverage</i> for more information.</p>	<p>Non-Medicare covered eyewear allowance: Plan reimburses up to \$160 every year for non-Medicare covered prescription eyewear.</p> <p>You do not have to use an in-network provider for your non-Medicare covered eyewear services. See the <i>Evidence of Coverage</i> for more information.</p>
<b>Fitness program</b>	<p>Fitness programs are provided by SilverSneakers®.</p>	<p>Fitness programs are provided by SilverSneakers®.</p> <p><b>Fitness Reimbursement</b> In addition, plan reimburses up to \$800 every year toward certain aerobic/fitness activity fees, membership fees, activity fees, activity supplies, fitness supplies and wearable items.</p> <p>See the <i>Evidence of Coverage</i> for more information.</p>
<b>Glaucoma screenings</b>	<p>Out-of-Network: You pay 50% of the total cost for each Medicare-covered service.</p>	<p>Out-of-Network: You pay 20% of the total cost for each Medicare-covered service.</p>
<b>Hearing aid fitting and evaluations</b>	<p>In-Network: You pay a \$25 copay for each non-Medicare covered service (one hearing aid fitting/evaluation every year).</p>	<p>In-Network: You pay a \$0 copay for each non-Medicare covered service (one hearing aid fitting/evaluation every year).</p>
<b>Hearing aids</b>	<p>Hearing aids are <u>not</u> covered.</p>	<p>Hearing aid maximum benefit allowance: Plan pays up to \$1,250 per ear for hearing aids every year.</p> <p>Hearing aids: \$0 copay (two hearing aids every year).</p> <p>Hearing aids are provided by NationsHearing. See the <i>Evidence of Coverage</i> for more information.</p>
<b>Hearing exams</b>	<p>In-Network: You pay a \$25 copay for each Medicare-covered service.</p>	<p>In-Network: You pay a \$20 copay for each Medicare-covered service.</p>

<b>Cost</b>	<b>2023 (this year)</b>	<b>2024 (next year)</b>
<b>Hearing exams</b>	Out-of-Network: You pay a \$60 copay for each Medicare-covered service.	Out-of-Network: You pay a \$30 copay for each Medicare-covered service.
<b>Hearing exams (routine)</b>	Out-of-Network: You pay a \$60 copay for each non-Medicare covered service (one exam every year). The number of visits includes services from both network and out-of-network providers.	Out-of-Network: You pay a \$30 copay for each non-Medicare covered service (one exam every year). The number of visits includes services from both network and out-of-network providers.
<b>Home health care services</b>	Out-of-Network: You pay 50% of the total cost for each Medicare-covered service.	Out-of-Network: You pay 20% of the total cost for each Medicare-covered service.
<b>Inpatient hospital care</b>	Out-of-Network: You pay 50% per stay for each medically necessary covered inpatient stay.	Out-of-Network: You pay \$395 per day, days 1-6; \$0 per day, days 7-90; \$0 copay for additional days for each medically necessary covered inpatient stay.
<b>Inpatient services in a psychiatric hospital</b>	In-Network: You pay \$324 per day, days 1-5; \$0 per day, days 6-90 for each medically necessary covered inpatient stay.	In-Network: You pay \$270 per day, days 1-8; \$0 per day, days 9-90 for each medically necessary covered inpatient stay.
<b>Inpatient services in a psychiatric hospital</b>	Out-of-Network: You pay 50% per stay for each medically necessary covered inpatient hospital stay.	Out-of-Network: You pay 20% per stay for each medically necessary covered inpatient hospital stay.
<b>Intensive cardiac rehabilitation services</b>	Out-of-Network: You pay 50% of the total cost for each Medicare-covered service.	Out-of-Network: You pay 20% of the total cost for each Medicare-covered service.
<b>Lab services</b>	Out-of-Network: You pay 50% of the total cost for each Medicare-covered service.	Out-of-Network: You pay 20% of the total cost for each Medicare-covered service.
<b>Meals (post-discharge)</b>	Qualifying members will receive frozen food after being released from the hospital. Meals are provided by GA Foods.	Qualifying members will receive fresh food after being released from the hospital. Meals are provided by NationsMarket.
<b>Medicare Part B prescription drugs</b>	Out-of-Network: You pay 50% of the total cost for each Medicare-covered service.	Out-of-Network: You pay 20% of the total cost for each Medicare-covered service.
<b>Occupational therapy services</b>	In-Network: You pay a \$35 copay for each Medicare-covered service.	In-Network: You pay a \$20 copay for each Medicare-covered service.

Cost	2023 (this year)	2024 (next year)
<b>Occupational therapy services</b>	Out-of-Network: You pay 50% of the total cost for each Medicare-covered service.	Out-of-Network: You pay a \$30 copay for each Medicare-covered service.
<b>Opioid treatment program services</b>	Out-of-Network: You pay 50% of the total cost for each Medicare-covered service.	Out-of-Network: You pay 20% of the total cost for each Medicare-covered service.
<b>Outpatient dialysis services, self-dialysis training, certain home support services, and home dialysis equipment and supplies</b>	Out-of-Network: You pay 50% of the total cost for each Medicare-covered service.	Out-of-Network: You pay 20% of the total cost for each Medicare-covered service.
<b>Outpatient hospital observation services</b>	In-Network: You pay a \$200 copay for each Medicare-covered service.	In-Network: You pay a \$295 copay for each Medicare-covered service.
<b>Outpatient hospital observation services</b>	Out-of-Network: You pay 50% of the total cost for each Medicare-covered service.	Out-of-Network: You pay a \$395 copay for each Medicare-covered service.
<b>Outpatient hospital services</b>	In-Network: You pay a \$25 - \$200 copay for each Medicare-covered service. The minimum cost share applies to non-surgical services and the maximum cost share applies to surgical services delivered in an outpatient hospital setting that are not specifically described elsewhere in the <i>Evidence of Coverage</i> .	In-Network: You pay a \$20 - \$295 copay for each Medicare-covered service. The minimum cost share applies to non-surgical services and the maximum cost share applies to surgical services delivered in an outpatient hospital setting that are not specifically described elsewhere in the <i>Evidence of Coverage</i> .
<b>Outpatient medical supplies</b>	Out-of-Network: You pay 45% of the total cost for each Medicare-covered item.	Out-of-Network: You pay 20% of the total cost for each Medicare-covered item.
<b>Outpatient mental health care services</b>	Out-of-Network: You pay 50% of the total cost for each Medicare-covered service.	Out-of-Network: You pay 20% of the total cost for each Medicare-covered service.
<b>Outpatient psychiatric services</b>	Out-of-Network: You pay 50% of the total cost for each Medicare-covered service.	Out-of-Network: You pay 20% of the total cost for each Medicare-covered service.
<b>Outpatient substance abuse services</b>	Out-of-Network: You pay 50% of the total cost for each Medicare-covered service.	Out-of-Network: You pay 20% of the total cost for each Medicare-covered service.
<b>Outpatient surgery provided at ambulatory surgical centers</b>	In-Network: You pay a \$200 copay for each Medicare-covered service.	In-Network: You pay a \$195 copay for each Medicare-covered service.



<b>Cost</b>	<b>2023 (this year)</b>	<b>2024 (next year)</b>
<b>Outpatient surgery provided at ambulatory surgical centers</b>	Out-of-Network: You pay 50% of the total cost for each Medicare-covered service.	Out-of-Network: You pay a \$295 copay for each Medicare-covered service.
<b>Outpatient surgery provided at hospital outpatient facilities</b>	In-Network: You pay a \$200 copay for each Medicare-covered service.	In-Network: You pay a \$295 copay for each Medicare-covered service.
<b>Outpatient surgery provided at hospital outpatient facilities</b>	Out-of-Network: You pay 50% of the total cost for each Medicare-covered service.	Out-of-Network: You pay a \$395 copay for each Medicare-covered service.
<b>Partial hospitalization services and Intensive outpatient services</b>	Out-of-Network: You pay 50% of the total cost for each Medicare-covered service.	Out-of-Network: You pay 20% of the total cost for each Medicare-covered service.
<b>Physical therapy and speech therapy services</b>	In-Network: You pay a \$35 copay for each Medicare-covered service.	In-Network: You pay a \$20 copay for each Medicare-covered service.
<b>Physical therapy and speech therapy services</b>	Out-of-Network: You pay 50% of the total cost for each Medicare-covered service.	Out-of-Network: You pay a \$30 copay for each Medicare-covered service.
<b>Physician specialist services</b>	In-Network: You pay a \$25 copay for each Medicare-covered service.	In-Network: You pay a \$20 copay for each Medicare-covered service.
<b>Physician specialist services</b>	Out-of-Network: You pay a \$60 copay for each Medicare-covered service.	Out-of-Network: You pay a \$30 copay for each Medicare-covered service.
<b>Podiatry services</b>	In-Network: You pay a \$25 copay for each Medicare-covered service.	In-Network: You pay a \$20 copay for each Medicare-covered service.
<b>Podiatry services</b>	Out-of-Network: You pay a \$60 copay for each Medicare-covered service.	Out-of-Network: You pay a \$30 copay for each Medicare-covered service.
<b>Primary care physician (PCP) services</b>	Out-of-Network: You pay a \$55 copay for each Medicare-covered service.	Out-of-Network: You pay a \$10 copay for each Medicare-covered service.
<b>Prosthetic devices</b>	Out-of-Network: You pay 45% of the total cost for each Medicare-covered item.	Out-of-Network: You pay 20% of the total cost for each Medicare-covered item.
<b>Pulmonary rehabilitation services</b>	In-Network: You pay a \$20 copay for each Medicare-covered service.	In-Network: You pay a \$15 copay for each Medicare-covered service.
<b>Pulmonary rehabilitation services</b>	Out-of-Network: You pay 50% of the total cost for each Medicare-covered service.	Out-of-Network: You pay 20% of the total cost for each Medicare-covered service.

<b>Cost</b>	<b>2023 (this year)</b>	<b>2024 (next year)</b>
<b>Skilled nursing facility (SNF) services</b>	In-Network: \$0 per day, days 1-20; \$196 per day, days 21-100	In-Network: \$0 per day, days 1-20; \$203 per day, days 21-100
<b>Skilled nursing facility (SNF) services</b>	Out-of-Network: 50% per stay	Out-of-Network: 20% per stay
<b>Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) services</b>	In-Network: You pay a \$30 copay for each Medicare-covered service.	In-Network: You pay a \$25 copay for each Medicare-covered service.
<b>Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) services</b>	Out-of-Network: You pay 50% of the total cost for each Medicare-covered service.	Out-of-Network: You pay 20% of the total cost for each Medicare-covered service.
<b>Telehealth additional services — Occupational therapy</b>	You pay a \$35 copay for each additional telehealth service.	You pay a \$20 copay for each additional telehealth service.
<b>Telehealth additional services — Physical therapy and speech therapy</b>	You pay a \$35 copay for each additional telehealth service.	You pay a \$20 copay for each additional telehealth service.
<b>Telehealth additional services — physician specialist</b>	You pay a \$25 copay for each additional telehealth service.	You pay a \$20 copay for each additional telehealth service.
<b>Telehealth additional services — urgent care</b>	You pay a \$25 copay for each additional telehealth service.	You pay a \$20 copay for each additional telehealth service.
<b>Therapeutic radiology services</b>	Out-of-Network: You pay 50% of the total cost for each Medicare-covered service.	Out-of-Network: You pay 20% of the total cost for each Medicare-covered service.
<b>Urgently needed care services</b>	You pay a \$0-\$25 copay for each Medicare-covered service. The minimum cost share is for services provided by your primary care physician in their office. The maximum cost share is for services performed by a provider other than your primary care physician.	You pay a \$20 copay for each Medicare-covered service. This includes urgently needed care services performed by a provider other than your primary care physician.
<b>Urgently needed care services (worldwide)</b>	You pay a \$90 copay for each non-Medicare covered service.  There is a \$250,000 combined maximum benefit for worldwide emergency and urgent care annually.	You pay a \$100 copay for each non-Medicare covered service.  There is a \$250,000 combined maximum benefit for worldwide emergency and urgent care annually.



Cost	2023 (this year)	2024 (next year)
<b>Wigs</b>	Wigs are <u>not</u> covered.	Plan pays up to \$400 every year for covered wigs related to hair loss from chemotherapy.
<b>X-rays</b>	Out-of-Network: You pay 50% of the total cost for each Medicare-covered service.	Out-of-Network: You pay 20% of the total cost for each Medicare-covered service.

## Section 1.5 Changes to Part D Prescription Drug Coverage

### Changes to Our “Drug List”

Our list of covered drugs is called a Formulary or “Drug List.” A copy of our “Drug List” is provided electronically.

We made changes to our “Drug List”, which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs or moving them to a different cost-sharing tier. **Review the “Drug List” to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the “Drug List” are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online “Drug List” to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your *Evidence of Coverage* and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Member Services for more information.

### Changes to Prescription Drug Costs

**Note:** If you are in a program that helps pay for your drugs (“Extra Help”), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also called the Low Income Subsidy Rider or the LIS Rider), which tells you about your drug costs. If you receive “Extra Help” and you haven’t received this insert by September 30th, please call Member Services and ask for the LIS Rider.

There are four **drug payment stages**. The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage.)

**Changes to the Deductible Stage**

<b>Stage</b>	<b>2023 (this year)</b>	<b>2024 (next year)</b>
<b>Stage 1: Yearly Deductible Stage</b>	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

**Changes to Your Cost Sharing in the Initial Coverage Stage**

Stage	2023 (this year)	2024 (next year)
<p><b>Stage 2: Initial Coverage Stage</b> During this stage, the plan pays its share of the cost of your drugs, and <b>you pay your share of the cost.</b></p> <p>Most adult Part D vaccines are covered at no cost to you.</p> <p>The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy.</p> <p>For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of the <i>Evidence of Coverage</i>.</p> <p>We changed the tier for some of the drugs on our “Drug List”. To see if your drugs will be in a different tier, look them up on the “Drug List”.</p>	<p>Your cost for a one-month supply at a network pharmacy:</p> <p><b>Tier 1 – Preferred Generic:</b>  <i>Standard cost-sharing:</i>                      You pay \$3 per prescription.</p> <p><i>Preferred cost-sharing:</i>                      You pay \$0 per prescription.</p> <p><b>Tier 2 – Generic:</b>  <i>Standard cost-sharing:</i>                      You pay \$7 per prescription.</p> <p><i>Preferred cost-sharing:</i>                      You pay \$5 per prescription.</p> <p><b>Tier 3 – Preferred Brand:</b>  <i>Standard cost-sharing:</i>                      You pay \$47 per prescription.                      You pay \$35 per month supply of each covered insulin product on this tier.</p> <p><i>Preferred cost-sharing:</i>                      You pay \$47 per prescription.                      You pay \$35 per month supply of each covered insulin product on this tier.</p> <p><b>Tier 4 – Non-Preferred Drug:</b>  <i>Standard cost-sharing:</i>                      You pay \$100 per prescription.</p> <p><i>Preferred cost-sharing:</i>                      You pay \$100 per prescription.</p>	<p>Your cost for a one-month supply at a network pharmacy:</p> <p><b>Tier 1 – Preferred Generic:</b>  <i>Standard cost-sharing:</i>                      You pay \$5 per prescription.</p> <p><i>Preferred cost-sharing:</i>                      You pay \$0 per prescription.</p> <p><b>Tier 2 – Generic:</b>  <i>Standard cost-sharing:</i>                      You pay \$10 per prescription.</p> <p><i>Preferred cost-sharing:</i>                      You pay \$5 per prescription.</p> <p><b>Tier 3 – Preferred Brand:</b>  <i>Standard cost-sharing:</i>                      You pay \$47 per prescription.                      You pay \$35 per month supply of each covered insulin product on this tier.</p> <p><i>Preferred cost-sharing:</i>                      You pay \$47 per prescription.                      You pay \$35 per month supply of each covered insulin product on this tier.</p> <p><b>Tier 4 – Non-Preferred Drug:</b>  <i>Standard cost-sharing:</i>                      You pay \$100 per prescription.</p> <p><i>Preferred cost-sharing:</i>                      You pay \$100 per prescription.</p>

Stage	2023 (this year)	2024 (next year)
	<p><b>Tier 5 – Specialty:</b>  <i>Standard cost-sharing:</i>            You pay 33% of the total cost.            You pay \$35 per month supply of each covered insulin product on this tier.</p> <p><i>Preferred cost-sharing:</i>            You pay 33% of the total cost.            You pay \$35 per month supply of each covered insulin product on this tier.</p> <p>Once your total drug costs have reached \$4,660, you will move to the next stage (the Coverage Gap Stage).</p>	<p><b>Tier 5 – Specialty:</b>  <i>Standard cost-sharing:</i>            You pay 33% of the total cost.            You pay \$35 per month supply of each covered insulin product on this tier.</p> <p><i>Preferred cost-sharing:</i>            You pay 33% of the total cost.            You pay \$35 per month supply of each covered insulin product on this tier.</p> <p>Once your total drug costs have reached \$5,030, you will move to the next stage (the Coverage Gap Stage).</p>

### Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages — the Coverage Gap Stage and the Catastrophic Coverage Stage — are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage.**

**Beginning in 2024, if you reach the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs.**

For specific information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

## SECTION 2 Deciding Which Plan to Choose

Section 2.1 If you want to stay in Aetna Medicare Premier Plus Plan (PPO)

**To stay in our plan, you don't need to do anything.** If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our Aetna Medicare Premier Plus Plan (PPO).

Section 2.2 If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2024 follow these steps:

### Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- –OR– You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see

Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder ([www.medicare.gov/plan-compare](http://www.medicare.gov/plan-compare)), read the *Medicare & You 2024* handbook, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

## Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Aetna Medicare Premier Plus Plan (PPO).
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from Aetna Medicare Premier Plus Plan (PPO).
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact Member Services if you need more information on how to do so.
  - –OR– Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

## SECTION 3 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2024.

### Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. Examples include people with Medicaid, those who get “Extra Help” paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

If you enrolled in a Medicare Advantage Plan for January 1, 2024, and don’t like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2024.

If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

## SECTION 4 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state.

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. SHIP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call SHIP at the phone number below.

State Health Insurance Assistance Program (SHIP)	
NC	Seniors' Health Insurance Information Program (SHIIP), Address: Albemarle

<b>State Health Insurance Assistance Program (SHIP)</b>	
	Building, 325 N. Salisbury Street, Raleigh, NC 27603, <b>Phone:</b> 1-855-408-1212, <b>TTY:</b> 711, <b>Hours:</b> Monday–Friday 8:00 AM to 5:00 PM, <b>Website:</b> <a href="https://ncdoi.gov/consumers/medicare-and-seniors-health-insurance-information-program-shiip">ncdoi.gov/consumers/medicare-and-seniors-health-insurance-information-program-shiip</a>

## SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **“Extra Help” from Medicare.** People with limited incomes may qualify for “Extra Help” to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don’t even know it. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
  - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call 1-800-325-0778; or
  - Your State Medicaid Office (applications).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the ADAP for your state. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the ADAP for your state.

<b>State AIDS Drug Assistance Programs (ADAP)</b>	
<b>NC</b>	<b>North Carolina HIV Medication Assistance Program (NC HMAP), Address:</b> NC Department of Health and Human Services Division of Public Health, Purchase of Medical Care Services, 1907 Mail Service Center, Raleigh, NC 27699-1907, <b>Phone:</b> 1-877-466-2232, 919-733-9161, <b>TTY:</b> 711, <b>Hours:</b> Monday–Friday 8:00 AM to 5:00 PM, <b>Website:</b> <a href="https://epi.dph.ncdhhs.gov/cd/hiv/hmap.html">epi.dph.ncdhhs.gov/cd/hiv/hmap.html</a>

## SECTION 6 Questions?

Section 6.1	Getting Help from Aetna Medicare Premier Plus Plan (PPO)
-------------	--

Questions? We’re here to help. Please call Member Services at 1-833-570-6670 or the number on your member ID card (TTY only, call 711). We are available for phone calls 8 AM to 8 PM, 7 days a week. Calls to these numbers are free.

### **Read your 2024 Evidence of Coverage (it has details about next year’s benefits and costs)**

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2024. For details, look in the *2024 Evidence of Coverage* for Aetna Medicare Premier Plus Plan (PPO). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is

located on our website at [AetnaMedicare.com](https://www.aetna.com). You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

**Visit our Website**

You can also visit our website at [AetnaMedicare.com](https://www.aetna.com). As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our *List of Covered Drugs (Formulary/“Drug List”)*.

Section 6.2	Getting Help from Medicare
-------------	----------------------------

To get information directly from Medicare:

**Call 1-800-MEDICARE (1-800-633-4227)**

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

**Visit the Medicare Website**

You can visit the Medicare website ([www.medicare.gov](https://www.medicare.gov)). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to [www.medicare.gov/plan-compare](https://www.medicare.gov/plan-compare).

**Read Medicare & You 2024**

Read the *Medicare & You 2024* handbook. Every fall, this document is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (<https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf>) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.



See the *Evidence of Coverage* for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Out-of-network/non-contracted providers are under no obligation to treat plan members, except in emergency situations. Please call our customer service number or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.

The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

The Aetna Medicare pharmacy network includes limited lower cost, preferred pharmacies in: Suburban Arizona, Suburban Illinois, Urban Kansas, Rural Michigan, Urban Michigan, Urban Missouri, Rural North Dakota, Suburban West Virginia. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, please call the number on your ID card (TTY: 711) or consult the online pharmacy directory at [AetnaMedicare.com/findpharmacy](https://www.aetnamedicare.com/findpharmacy).

To send a complaint to Aetna, call the Plan or the number on your member ID card. To send a complaint to Medicare, call 1-800-MEDICARE (TTY users should call 1-877-486-2048), 24 hours a day/7 days a week). If your complaint involves a broker or agent, be sure to include the name of the person when filing your grievance.

For mail order, you can get prescription drugs shipped to your home through the network mail order delivery program. Typically, mail order drugs arrive within 10 days. You can call 1-833-570-6670 or the number on your member ID card (TTY: 711) 8 AM to 8 PM, 7 days a week if you do not receive your mail order drugs within this timeframe. Members may have the option to sign up for automated mail-order delivery.



We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex and does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. If you speak a language other than English, free language assistance services are available. Visit our website, call the phone number listed in this material or the phone number on your benefit ID card.

In addition, our health plan provides auxiliary aids and services, free of charge, when necessary, to ensure that people with disabilities have an equal opportunity to communicate effectively with us. Our health plan also provides language assistance services, free of charge, for people with limited English proficiency. If you need these services, visit our website, call the phone number listed in this material or on your benefit ID card.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Grievance Department (write to the address listed in your Evidence of Coverage). You can also file a grievance by phone by calling the Customer Service phone number listed on your benefit ID card (TTY: 711). If you need help filing a grievance, call Customer Service Department at the phone number on your benefit ID card.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at [https://ocrportal.hhs.gov/ocr/cp/complaint\\_frontpage.jsf](https://ocrportal.hhs.gov/ocr/cp/complaint_frontpage.jsf).

**ESPAÑOL (SPANISH):** Si habla un idioma que no sea inglés, se encuentran disponibles servicios gratuitos de asistencia de idiomas. Visite nuestro sitio web o llame al número de teléfono que figura en este documento.

**傳統漢語(中文) (CHINESE):** 如果您使用英文以外的語言，我們將提供免費的語言協助服務。請瀏覽我們的網站或撥打本文件中所列的電話號碼。

## How we guard your privacy

### What personal information is — and what it isn't

By “personal information,” we mean information that can be used to identify you. It can include financial and health information. It doesn't include what the public can easily see. For example, anyone can look at what your plan covers.

### How we get information about you

We get information about you from many sources, including you. We also get information from your employer, other insurers, or health care providers like doctors.

### When information is wrong

Do you think there's something wrong or missing in your personal information? You can ask us to change it. The law says we must do this in a timely way. If we disagree with your change, you can file an appeal. Information on how to file an appeal is on our member website. Or you can call the toll-free number on your ID card.

### How we use this information

When the law allows us, we use your personal information both inside and outside our company. The law says we don't need to get your OK when we do. We may use it for your health care or use it to run our plans. We also may use your information when we pay claims or work with other insurers to pay claims. We may use it to make plan decisions, to do audits, or to study the quality of our work. This means we may share your information with doctors, dentists, pharmacies, hospitals or other caregivers. We also may share it with other insurers, vendors, government offices, or third-party administrators. But by law, all these parties must keep your information private.

### When we need your permission

There are times when we do need your permission to disclose personal information. This is explained in our Notice of Privacy Practices, which took effect October 10, 2020. This notice clarifies how we use or disclose your Protected Health Information (PHI):

- For workers' compensation purposes
- As required by law
- About people who have died
- For organ donation
- To fulfill our obligations for individual access and HIPAA compliance and enforcement

To get a copy of this notice, just visit our member website or call the toll-free number on your ID card.

## Multi-Language Insert Multi-language Interpreter Services

**English:** We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-833-570-6670. Someone who speaks English can help you. This is a free service.

**Spanish:** Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-833-570-6670. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

**Chinese Mandarin:** 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-833-570-6670。我们的中文工作人员很乐意帮助您。这是一项免费服务。

**Chinese Cantonese:** 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-833-570-6670。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

**Tagalog:** Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-833-570-6670. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

**French:** Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-833-570-6670. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

**Vietnamese:** Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-833-570-6670. sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

**German:** Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-833-570-6670. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-833-570-6670. 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

**Russian:** Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-833-570-6670. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

**Arabic:** إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-833-570-6670. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

**Hindi:** हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-833-570-6670 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

**Italian:** È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-833-570-6670. Un nostro incaricato che parla Italiano fornirà l'assistenza necessaria. È un servizio gratuito.

**Portuguese:** Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-833-570-6670. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

**French Creole:** Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-833-570-6670. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

**Polish:** Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-833-570-6670. Ta usługa jest bezpłatna.

**Japanese:** 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-833-570-6670にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。





**Hawaiian:** He kōkua māhele 'ōlelo kā mākou i mea e pane 'ia ai kāu mau nīnau e pili ana i kā mākou papahana olakino a lā'au lapa'au paha. I mea e loa'a ai ke kōkua māhele 'ōlelo, e kelepona mai iā mākou ma 1-833-570-6670. E hiki ana i kekahi mea 'ōlelo Pelekānia/'Ōlelo ke kōkua iā 'oe. He pōmaika'i manuahi kēia.

Y0001\_NR\_30475b\_2023\_C

Form CMS-10802  
(Expires 12/31/25)



## Aetna Medicare Premier Plus Plan (PPO) Member Services

Method	Member Services – Contact Information
<b>CALL</b> 	1-833-570-6670 or the number on your member ID card Calls to this number are free. Hours of operation are 8 AM to 8 PM, 7 days a week. Member Services also has free language interpreter services available for non-English speakers.
<b>TTY</b> 	711 Calls to this number are free. Hours of operation are 8 AM to 8 PM, 7 days a week.
<b>WRITE</b> 	Aetna Medicare PO Box 7405 London, KY 40742
<b>WEBSITE</b> 	Go to <a href="https://www.aetnamedicare.com/H5521-170">AetnaMedicare.com/H5521-170</a> or scan this code with your smartphone to visit our website. 